

EXHIBIT D

**CONSENT TO FORENSIC PSYCHIATRIC/PSYCHOLOGICAL EVALUATION:
INDEPENDENT MEDICAL EXAMINATION
PERSONAL INJURY**

Examinee's Name: E. Jean Carroll

Date of Birth: 12/12/43

Date of Injury: 1995/1996

Case Caption: E. Jean Carroll v. Donald J. Trump
No. 22 Civ. 10016 (LAK)

Attorneys for Examinee: Roberta A. Kaplan, Esq.
Matthew J. Craig, Esq.
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350 Fifth Avenue
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Referred by: Matthew DeOreo, Esq.
Tacopina, Seigel & DeOreo
275 Madison Avenue
New York, NY 10016

Examiners' Names: Ian C. Lamoureux, M.D. and Jill Hayes, Ph.D.

Date/Place: February 20, 2022
TBA with Dr. Lamoureux

Zoom:
<https://us02web.zoom.us/j/81515700496?pwd=Z05pR3JtUGI1bVR2UU1TZFYzNjdZUT09>

Meeting ID: 815 1570 0496
Passcode: 848723

1. I understand that I have been referred to Drs. Ian Lamoureux and Jill Hayes by the law firm Tacopina, Seigel & DeOreo (Matthew DeOreo, Esq.), who represents the defendant(s) in my lawsuit, and that the purpose of the examination is for Drs. Lamoureux and Hayes to evaluate me for emotional/psychological harm/"damages" resulting from the actions of the Defendant(s) in my personal injury claim. My signature on this document indicates that I understand why this evaluation is being done and have consented to undergo the evaluation.
2. I understand that during this evaluation, Drs. Lamoureux and/or Hayes may ask me questions about my past, including my personal, family, education, employment,

relationship, psychiatric, medical, drug/alcohol, and legal histories, and my current symptoms and functioning. Drs. Lamoureux and Hayes will also administer psychological testing.

3. I understand that the evaluation with Drs. Lamoureux and Hayes will be video and audio-recorded. I have given my consent to have the evaluation recorded. The video-recording will be provided to my attorney. It is possible that portions of the video-recording may be presented to a jury or in a deposition involving my claim. A transcript will be made of this recording as well.
4. I understand that as a result of this evaluation, Dr. Lamoureux will prepare a written report about my psychiatric/psychological symptoms, current functioning, medical/psychiatric/psychological history, and his professional opinions about the presence of a psychiatric disorder and its relation to the injury I sustained.
5. I understand that Dr. Lamoureux's opinions may help, harm, or have no bearing on my case.
6. I understand that Dr. Lamoureux will not provide me with a copy of his report; will not advise me as to his opinions, but will provide his report to Matthew DeOreo at Tacopina, Seigel & DeOreo, who has requested the evaluation. I understand that my attorneys will also receive a copy of the report.
7. I understand that Drs. Lamoureux and/or Hayes may testify in a deposition or trial about the opinions formed as a result of this evaluation.
8. I understand that I do not have to answer any questions which I find too distressing, although Drs. Lamoureux and/or Hayes may ask me for my reasons and may record those reasons in the report.
9. I understand that Drs. Lamoureux and Hayes will not provide treatment of any kind to me, including medications, therapy, referrals, recommendations, or advice now or in the future. However, Dr. Lamoureux may form opinions about my need for treatment and may include these opinions in his report or testimony. As such, there will be no "doctor-patient relationship" in the usual sense.
10. I understand that Drs. Lamoureux and Hayes may have a "duty to warn" an individual if they form the opinion that I represent a risk of danger or harm to myself, a specific individual, or individuals, and/or they may have a duty to protect the intended victim(s), which may include alerting law enforcement officials; and/or may involve warning the potential victim directly.
11. I understand that there may be circumstances in which Drs. Lamoureux and Hayes may be required to release information about me without my consent, regarding the abuse or neglect of children or vulnerable adults, if they believe I have abused or neglected or will abuse or neglect a child, children, or vulnerable adults.
12. I understand that I may withdraw or rescind my consent at any time during the evaluation, and I must notify my attorney of that decision. I understand that if I inform Drs. Lamoureux and Hayes of my decision to rescind my consent, Matthew DeOreo will be notified.

13. I will be given the chance to ask questions regarding the evaluation.

Examinee Signature

Date